

§ 419.30

42 CFR Ch. IV (10–1–13 Edition)

(p) Services that are not covered by Medicare by statute.

(q) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

(r) Services defined in § 419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

(u) Outpatient diabetes self-management training.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 69 FR 65863, Nov. 15, 2004; 75 FR 72265, Nov. 24, 2010; 78 FR 50969, Aug. 19, 2013]

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) CMS estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of coinsurance that would be payable by beneficiaries to hospitals for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part.

(b) The estimated aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory payment classification (APC) system and payment weights.

(a) *APC groups.* (1) CMS classifies outpatient services and procedures

that are comparable clinically and in terms of resource use into APC groups. Except as specified in paragraph (a)(2) of this section, items and services within a group are not comparable with respect to the use of resources if the highest geometric mean cost for an item or service within the group is more than 2 times greater than the lowest geometric mean cost for an item or service within the group.

(2) CMS may make exceptions to the requirements set forth in paragraph (a)(1) in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) The payment rate determined for an APC group in accordance with § 419.32, and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part, apply to

(b) *APC weighting factors.* (1) Using hospital outpatient claims data from calendar year 1996 and data from the most recent available hospital cost reports, CMS determines the geometric mean costs for the services and procedures within each APC group.

(2) CMS assigns to each APC group an appropriate weighting factor to reflect the relative geometric mean costs for the services within the APC group compared to the geometric mean costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) CMS determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the “labor-related portion” of hospital outpatient costs.

(2) CMS standardizes the geometric mean costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

[65 FR 18542, Apr. 7, 2000, as amended at 77 FR 68558, Nov. 15, 2012]

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* CMS calculates a conversion factor in such a